intramaxillary bones in three, the carcinoma extended to the larynx in three, and upwards beyond the choanæ in two cases.

The first symptoms of the disease appeared three to fifteen months before consultation, but had existed probably prior to this without being remarked.

Pain in swallowing occurs relatively late, generally when the carcinoma has involved the palatal arches, palate, tongue and jaw bone. The diagnosis will not be difficult, when the tumor has reached the stage of ulceration, but at the commencement of the disease we are often in doubt as to its true nature.

L. S. PILCHER.

THE PARIS SOCIETY OF SURGERY AND THE QUESTION OF OPERATION FOR TUBERCULOUS JOINT DISEASE.

At the meeting of the Paris *Société de chirurgie* for the 10th of February last, Dr. Chauvel reported in detail upon a paper by Dr. Mabboux, of Lille, on the question of prognosis and operation in the tuberculous. The paper of Mabboux was based upon two cases of tuberculous joint disease, (1) the first originating in caries of the fourth metatarsal bone of a young soldier, with resection of the disease, which was followed by synovitis of the peroneal sheath and, later, by suppuration of the tibio-tarsal articulation and concomitant pulmonary tuberculosis; after three months, all the symptoms continuing to be more unfavorable, the foot was amputated, and rapid cure followed, with abatement and final disappearance of the pulmonary symptoms, the patient being in the enjoyment of robust health at the time of the writing of the paper; (2) the second case was apparently less favorable to the theory of operative intervention; a corporal of the line, æt. 24, entered the hospital at Lille in May, 1885, for arthritis of the left knee, consecutive to a fall received a month previously. He had had hæmoptysis in 1884 but had been well since then. In spite of immobilization and all other methods, the disease progressed until August 15, when the contents of the joint were found on aspiration to be purulent; indura-

tion at the apex of the left lung was observed and the patient was harrassed with a frequent cough. Arthrotomy was performed on the 24th, the pus evacuated, the fungosities removed and the denuded bone scraped. This was followed by redoubled suffering, probable meningitis and more pronounced pulmonary symptoms, with the formation of eschars at the sacrum and heels. In September, the pain became atrocious, and the emaciation extreme, the exhaustion complete, gangrene imminent and early death certain. In spite of the gravity of the situation, and in deference to the wishes of the moribund patient, the thigh was amputated in the lower third. Microscopical examination of the knee showed the lesions of tuberculous arthritis in the highest degree of development. Immediately after the operation, sleep returned to the patient, pain ceased, the wound cicatrized and he seemed to be saved, but on the 8th of October the fever reappeared, the stump ulcerated, the tuberculosis seemed to be localized in the abdominal viscera, and death ensued on the 18th of January following, but with no recurrence of the atrocious suffering for which the operation was performed. In view of the fact that there had been no therapeutic or operative success—nor indeed was one expected—was the operation justifiable? The author replied in the affirmative, considering the relief from pain and the consequent euthanasia to be abundant justification. That the later progress of the tuberculous disease was not due to the traumatism of the operation is emphatically shown by the manifest amelioration of the symptoms during the following twenty-five days, showing that, on the contrary, the disease was temporarily relieved by the operation, and only resumed its regular course after the beneficial effects of the intervention had been exhausted.

Mabboux concludes that (1) the existence of pulmonary tuberculous lesions, even of an advanced type, is not a contraindication to an amputation of a member affected with suppurative tuberculous synovitis, when the latter lesion predominates the pathological scene and menaces life. (2.) The operation, by suppressing the causes of exhaustion due to the articular lesion, can stop the progress of the visceral lesion, to the extent of replacing the lungs in a perfectly normal state. (3.) Even in cases where the phthisis follows its course, amputation of the diseased member may improve the condition of the patient, if only

by relieving the intolerable pain; consequently the policy of non-interference in cases where a curative action can not result, should not be carried into the treatment of this affection.

M. Chauvel, in commenting upon the paper, referred to the diametrically opposite views held by various surgeons with regard to the propriety and extent of operative interference and remarked that a precise, invariable rule with regard to action could not be laid down, but that each case must be treated as an individual entity. If the failure of operations and the prompt deaths attributable to surgical traumatism impress us, we must also not forget the deaths, slower, perhaps, but certainly more numerous, which result from non-intervention. These latter are attributed to the progress of an incurable disease, but is the physician any more justifiable in failing to interfere than he would be in any other otherwise incurable affection, such as œdema of the glottis or strangulated hernia?

Osseous and articular tubercular affections are not generally proper subjects for incomplete intervention. Perhaps the day is not far distant when osseous and articular tuberculosis, local tuberculosis, will be considered as a neoplasm, the more malignant from its tendency to generalization, and treated under the same rules as sarcoma and carcinoma. When the extirpation of the disease in place is impossible or when the anatomical conditions do not permit the complete and certain ablation of all the infected tissues—conditions not rarely present in osteitis and synovitis—early amputation is indicated. In the cases of Mabboux he thought the operation was delayed too long in the second case, if not in the first.

As shown by these cases, the existence of pulmonary tuberculous lesions should not be considered a contra-indication to operation. Cases of temporary cure under these conditions are common, and permanent cures are not the exception. Two years previously, M. Chauvel amputated the leg of an old soldier, affected with tuberculous disease of the tarsus with pulmonary and peritoneal tuberculariza tion,who had been bed-ridden for two years, and lay in a state of great exhaustion from fever and suppuration. Against the surgeon's judgment and in deference to the patient's wishes, the operation was performed, and, after repeated periodical hæmorrhages from the stump, it cicatrized,

and the patient, fully recovering after a tedious convalescence, was discharged completely cured. In closing, M. Chauvel emphasized the lesson of Mabboux's second case, that one of the indications for amputation in tuberculous joint-disease may be the relief of pain, even when the cure of the disease is hopeless.

M. Despres, although considering it almost useless, wished to protest against the belief in the theory of the generalization of tuberculosis by the propagation of a microbe. The question of amputation had long been under discussion, and, as it was still on trial, no absolute rules could be established for its application. He had amputated the thigh of a patient who had an ulcerated knee-joint disease and hæmoptysis. He was cured, but died two years later with tubercular ulcerations on the other leg. Tuberculous patients, affected with non-suppurating joint-disease, should be treated by immobilization and compression. Amputation may be of service to young men.

M. Lucas-Championnière considered the operation for the relief of intense pain, but without hope of ultimate cure, to be justifiable, in spite of the resulting damaging effects upon the statistics of the operation. The true question was whether an operation for the removal of a tubercular lesion in a tuberculous patient was good treatment. Ollier had shown in a recent work that operations, even partial ones, could be successfully performed on the tuberculous, and that in resections, diseased osseous parts could be left without preventing a cure; and after operations the patients grow fat and are greatly improved in physical condition. New trouble may supervene later, it is true, but even radical operations do not prevent later developments. He was then an advocate of surgical intervention in the tuberculous but, unlike M. Chauvel, he believed in the utility of partial ablation in certain cases.

M. Verneuil believed that in tuberculosis as in cancer, the surgeon should operate for the temporary relief of suffering, without necessarily expecting any permanent curative effect. But in tuberculous patients, affected with strumous synovitis, operative intervention was necessary only in case of the existence of sinuses and suppuration, for many cases were cured by compression. He did not perform more than two or three amputations a year for tuberculous articular affections and still

fewer resections. Resection of the hip-joint alone has caused more attacks of meningitis or rapid generalization of tuberculosis than all other operations performed in these conditions.

M. Berger had in a previous discussion cited some cases of rapid generalization of tuberculosis after amputation for chronic synovitis, but on the other hand, he had seen the disease clearly diminish in at least one case, in which he amputated the thigh of a young man in whom unequivocal signs of tubercularization existed, and who afterwards regained the best of health. And in an old man in whose lung cavities were discovered, and who was in a state of extreme debility, he saw radio-carpal amputation followed by an unexpected recovery. He believed that incomplete resections were bad practice in the tuberculous, and that primary union must be sought for, operating only in healthy parts.

M. Reclus had been greatly impressed by a case in which Lisfranc's disarticulation had been performed for caries of the first and second metatarsal bones, and in which primary union was obtained, but, after a few days, the patient developed a large fungus in a counter-opening on the plantar surface. The surgeon who succeeded M. Reclus in charge of the case, was frightened and proposed a second amputation; the patient, however, recovered without further interference so completely that a cast was made of the stump as a typical result of Lisfranc's operation.

M. Pozzi did not think that it was indispensable to operate in healthy parts when amputating in the tuberculous; he had made an amputation in the middle of the leg of a young female in the midst of fistulous sinuses, which had to be scraped and excised to refresh the flaps, and he obtained a very beautiful primary union. However, he considered that all diseased bone should be removed.

M. Richelot had removed only a part of the glands in a greatly emaciated young man with large suppurating glandular masses at the neck, in spite of which union was obtained and the glands, not removed, finally disappeared, while tuberculous disease of the elbow was developed.

M. Polaillon recalled that he had, two years previously, presented a patient whose wrist he had resected for tuberculous arthritis without

removing all the diseased parts, but who had recovered; he had also cited several cases in which amputation had improved the condition of tuberculous patients.

M. Le Fort believed that suppuration was not so much to be feared after amputation as might be thought; patients who became greatly emaciated before operation, while losing but small quantities of pus, often grow fat when, after amputation, the suppuration is abundant; a small amount of osseous suppuration is often sufficient to greatly exhaust patients. In his work on resections of the hip, he was able to give the later results of the operation in a number of patients and could see that death by meningitis was not by any means so frequent as M. Verneuil asserted. After resections the bone trouble was sometimes cured, while the disease recurred in the soft parts; he considered that incomplete resections did not give as good results in general as the complete. In conclusion, he remarked that he would consider tuberculous disease with great debility contra-indications to operation in aged but not in young patients.

M. Trelat believed that in operating upon a tuberculous patient all the diseased parts should be removed; if primary union failed, the minimum of suppuration should be sought for. However, the tuberculous patient is an individual affected with bacilli, and the operator can never be sure that he has removed the entire disease; cases of osteo-myelitis exist for years without becoming apparent; there was always then a certain amount of ignorance upon the part of the surgeon and a consequent amount of uncertainty as to the result; if a patient had been completely examined, however, before deciding upon operation, it would generally benefit him. He thought there were good reasons for holding that amputation was preferable to resection, but it could not be said that tubercularization invariably led to amputation rather than resection. The form and extent of the lesion should alone decide that question.

JAMES E. PILCHER.